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Brent

Health Partnerships Overview and Scrutiny Committee

Tuesday 8 October 2013 at 7.00 pm
Conference Hall - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Daly (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Sneddon	Brown
Colwill	Baker	Kansagra
Harrison	Singh	Naheerathan
Hector	Aden	Al-Ebadi
Hossain	Ogunro	RS Patel
Leaman	Green	Clues
Ketan Sheth	Gladbaum	Van Kalwala

For further information contact: Toby Howes, Senior Democratic Services Officer
020 8937 1307, toby.howes@brent.gov.uk

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The press and public are welcome to attend this meeting

recycle for Brent

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Deputations (if any)

3 Minutes of the previous meeting held on 24 July 2013 1 - 8

The minutes are attached.

4 Matters arising (if any)

5 GP and Primary Care Access and Service Provision 9 - 34

Two reports are included under this item, the first being the NHS England report outlining the general services provided by GPs under different contract types and summarising the contractual arrangements with GPs in Brent and the differing levels of access available at different practices across Brent. The second report outlines the aims of the former ACE programme undertaken in 2010/11, by the PCT, designed to improve GP access.

A number of appendices are attached to the reports and there are also two supplementary agenda packs containing other appendices.

6 Brent CCG: Wave 2 Commissioning 35 - 42

The covering and main report are both attached.

7 Pathology Service Serious Incident: Update Report 43 - 46

This report provided by Brent CCG gives a short update on plans for improving the courier service used for the pathology samples, which it says is now the only outstanding item from the Root Cause Analysis.

8 Central Middlesex Hospital Urgent Care Centre Serious Incident: Update Report 47 - 52

At the last meeting of the committee in July 2013, members requested an update on the actions undertaken following the serious incident at Central Middlesex Hospital Urgent Care Centre in 2012. The update is attached.

9 Health Partnerships Overview and Scrutiny work programme 2013-14 53 - 54

The work programme is attached.

10 Date of next meeting

The next meeting of the Health Partnerships Overview and Scrutiny Committee is scheduled to take place on Wednesday, 4 December 2013 at 7.00 pm.

11 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Please remember to SWITCH OFF your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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Brent

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday 24 July 2013 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Harrison, Hector, Hossain and Ketan Sheth

Also present: Councillors Butt, Cheese and Mitchell-Murray and health representatives Tina Benson, David Cheeseman, Jon Knott, Ethie Kong, Rob Larkman, Sarah Mansuralli and Ian Winstanley

Apologies for absence were received from: Councillors Colwill and Leaman

1. **Declarations of personal and prejudicial interests**

None declared.

2. **Minutes of the previous meeting**

Councillor Hunter informed the Committee that she had raised with Democratic Services that the health attendees be recorded as present on the minutes for information and courtesy. Members also raised concern was also raised that the minutes for the Pathology item did not record the response from the CCG and Dr Patel about whether TDL were accredited.

Councillor Hector highlighted that her request to amend the minutes of the meeting held on 19 March 2013 were not recorded and that Councillor Cheese's comments should be reflected as " Councillor Cheese knows from contacts examples of patients waiting hours on the ranks outside Northwick Park Hospital with staff going out to treat them on the rank."

RESOLVED:-

that the minutes of the previous meeting held on 11 June 2013 be approved as an accurate record of the meeting subject to the following amendment:

(i) Page 2, first and third paragraph to be amended to reflect that samples should be transported in temperature controlled containers

3. **Matters arising (if any)**

Sexual and Reproductive Health Service in Brent

It was clarified that sexual health prevention would be referred to as sexual health promotion in future.

4. **Brent CCG: Commissioning Intentions**

Sarah Mansuralli, Brent CCG informed the Committee that the report set out the work plan for 2013/14, objectives and approach, providing an overview of how budgets would be allocated. The report highlighted quality innovation and productivity plans as well as the way health services were commissioned and how the decision to procure services was taken. It was explained that there were three ways in which health services could be procured; rolling and varying existing contracts, "any qualified provider" and through a traditional tendering process. Under the NHS reforms, transactional support would be provided in terms of managing contract performance, business intelligence and supporting decisions to enable implementation by the CSU (Commissioning Support Unit). It was explained that there was a new interface of working with the CSU and although a few teething problems these were overcome through good governance and working relationship with the CSU.

Rob Larkman, CCG highlighted that the commissioning process was cyclical, where priorities were formed through consultation with public providers and the local authority and services commissioned to meet the needs of residents.

During discussion, members queried how the requirement to consult on commissioning decisions had been fulfilled. Rob Larkman informed the Committee that previous contracts such as out patient services were brought to the Committee for consultation. He clarified that the contracts for cardiology and ophthalmology were currently at the preferred provider stage and therefore some information was not available as it was commercially sensitive. Members queried the reliance on GPs to carry out additional cardiology and ophthalmology services. It was clarified that the bids were from secondary care providers moving into the community. Members highlighted that the contract specification appeared generic and appeared to suggest that there would be fewer first and second appointments for cardiology and ophthalmology and whether this represented a cut in the service. Ethie Kong clarified that the service would be complemented by those provided in primary care, resulting in the patient being able to receive greater services such as diagnostics and ECGs at a surgery rather than needing to be referred to hospital. Investment in cardiology equipment was taking place to offer an enhanced primary care service. In response to queried regarding other enhanced services provided, Ethie Kong explained that some GPs offered diabetes clinics with individual cases being supported and managed where appropriate. Enhanced services for ophthalmology included enhanced diagnostic checks through tracking high blood pressure rather than following the tradition route of referring to a hospital for basic checks. Ethie Kong highlighted in response to questions that she did not have specific data relating to the number of patients who had been referred to hospitals for ECGs but agreed to provide the Committee with a copy of the recent CCG investment study. Following queries in relation to the recent GP survey results and the lack of access to detailed data through the survey website, Ian Winstanley agreed to provide full data for Brent CCG and Brent GP practices broken down and analysed in a similar way to the survey received by the Committee several years ago. It was agreed that this information would be passed to the Committee, as the basis for an agenda item on G.P access at the next meeting. Ethie Kong informed the Committee that all 67 GP surgeries in Brent had signed up to receive investment and therefore all surgeries should have the same equipment to enable GPs to carry out service beyond the original contract. Following queries on how much had been invested, it

was agreed that this information would be provided. In response to queries when all surgeries would have the ECG machines, it was confirmed that all machines had been ordered however they would not be used until GPs had received appropriate training and if members had any specific surgeries they had queries on then specific information could be provided outside the meeting. Members queried how they intended surgery extended operating hours to work. It was explained that the extended operating hours linked to the GP locality service where each locality would have an extended practice in which GPs had a share. It was agreed that a detailed report would be brought to a future meeting for the Committee to explore GP access further. In response to queries regarding enhanced ophthalmology it was explained that all bids would include the ability for GPs to consult an optometrist prior to referring a patient and being able to refer directly as well as be supported by consultants to manage patients. Ian Winstanley felt it would be suitable for the providers once appointed to present the enhanced service offered to the Committee. Members queried diabetic retina screening and it was confirmed that this was the commissioning responsibility of NHS England and therefore CCG representatives would not have detailed information available for the Committee.

Members drew the CCG representative's attention to concern that stakeholders and residents had not been adequately consulted on the proposed commissioning arrangements. Sarah Mansuralli informed the panel that the CCG regularly consulted the public and patients and the commissioning arrangements specifically required that consultation took place. It was clarified that the procurement process required a statutory consultation with patients, the residents and patient representation on procurement panelsFwave, with the EDEN Committee ensuring that the CCG fulfilled its statutory consultation duties. In response to queries regarding rolling over existing contracts, it was clarified that following the establishment of the JSNA needs assessment and priorities, three waves of commissioning were agreed, with the next wave not commencing until the previous wave was completed. Wave 1 was the commissioning of cardiology/ophthalmology services; wave 2 is musculoskeletal/ rheumatology /trauma and orthopaedics/gynaecology; wave 3 is any other remaining services. It was explained that the majority of contracts were rolled over in line with NHS England Planning guidance with adjustments for QIPP embedded into contracts and budgets where possible. Contracts that required adjustment were negotiated early in the commissioning cycle to enable acute contract activity and investment. Sarah Mansuralli informed the Committee that procurement often took place due to poor provider performance, opportunity to commission innovative models of care, opportunity to provide services closer to home and potential to achieve better value for money. Ian Winstanley informed the Committee medical consultants were worked with to ensure best practice was sought and consulted as part of the process as well as undertaking the statutory consultation process. Rob Larkman clarified that consultation was embedded within the commissioning governance arrangements and consulted partners and stakeholders as well as the EDEN consultation group, going beyond the required statutory consultation. Rob Larkman agreed to provide the Committee with a list of consultees for cardiology and ophthalmology procurements. The Committee queried the provider for services where a reprocurement exercise had taken place and whether these services were suitable. It was confirmed that the existing service provider had received the decommissioning notices and continued to provide service until an appointment was made. It was explained that the current service provider had reapplied for the contract and audits had been carried out to ensure there had been no impact on

service delivery and to ensure patient safety. It was explained that the decision to reprocure occurred after the current service provider were unsure whether they would be able to meet the needs of the CCG following dialogue so it was agreed to test the market. It was clarified that a competitive dialogue was required to ensure that the CCG delivered the best service in terms of changes to technology and efficiencies. Rob Larkman informed the Committee that the service currently provided did not support patients close to home and was to be reoccurred to improve the service to individuals through the quality received and improved access. Members queried whether the improvements to service were based on GPs taking on additional work and whether this was feasible. It was clarified that this was dependent on the model procured from the competitive dialogue but GPs were to be looked at within the process. In response to queries regarding the improved health outcomes priority, it was explained that £13m will be invested into services through the assistance of QIPP to improve services such as dementia and learning disabilities, with a large quantity of the investment being released in 2013/14. In relation to the shaping healthier futures initiative, it was felt that the investment proposals supported the scheme due to the shift of providing out of hospital care enabling a safer sustainable service in hospitals. It was clarified that the investment was in line to support out of hospital services and to comply with legal standards, testing the market was required.

RESOLVED:

(i) That the report be noted
(ii) That a copy of the CCG investment study be provided
(iii) Information be provided regarding the level of investment in GP surgeries'
(iv) Information on Brent CCG and Brent GP practices broken down and analysed to be sent to the Committee based on the latest survey results
(v) A report be provided on the extended opening hours of GP surgeries
(vi) A list of consultees be provided to the Committee

5. **Emergency Services at North West London Hospitals**

Tina Benson, Director of Operations, informed the Committee that the report addressed the emergency care pathways, the work required to enable improvements and the strategies that had already been put in place. It was reported that there had been a positive impact with the target for 95% of A&E patients to be seen within four hours being met for the past two months. It was reported that there were no incidents of patients being treated in the ambulance in June and an average of two cases per week where patients had to wait in the ambulance for 30 minutes. It was clarified that bed capacity was a key issue in the A&E department and to cope with surges in demand, a lower occupancy level was required. Concern was expressed regarding the bed occupancy level in the future winter months and weekly meetings were taking place between CCG and GP representatives to ensure pathways were in place to enable more bed spaces to be released in the A&E department. Tina Benson drew the Committees attention to a non compliance of section 19 of the Health Social Care Act 2008 following an unannounced visit by the CQC. It was explained that the non compliance related to a do not resuscitate form that had not been countersigned by the consultant and an action plan had been put in place to address this. Internal audits had been carried

out successfully. St Marks had been revisited by the CQC and found to be compliant and Northwick Park Hospital was awaiting a revisit from the CQC to assess its compliance.

During discussion, members queried the use of Central Middlesex Hospital. It was explained that the hospital was being used proactively with an increase in conveyances and a maintained 24 hour urgent care centre. It was reported that the emergency department operated from 8am-7pm with patients being seen by the urgent care centre after 7pm. It was highlighted that an enhanced recovery service was offered at Central Middlesex Hospital that enabled a faster recovery rate and increased survival rate for surgery on fractured hips.

Jon Knott, London Ambulance Service informed the Committee that there had been a 6.2% increase in admittance to Central Middlesex Hospital and a decrease at Northwick Park, demonstrating the successful support of Northwick Park Hospital. It was highlighted that there had been an increase in accessing alternative services rather than calling an ambulance. It was also pointed outthat a number of residents located in the South of the borough werebeing taken to St Mary's Hospital. Members queried why residents from the Harlesden ward despite living in close proximity to Central Middlesex Hospital were taken to St Mary's. Jon Knott explained that each hospital provided different services and specialisms and it may be more appropriate in certain cases to bypass the local hospital and go to one that had a centre of excellence. Members queried the "non conveyed" figures for ambulance attendances and how these arose. It was confirmed that one of the reasons that patients may not be conveyed would be if they have passed away. Other reasons would be that it was not necessary to convey them because they could be treated on site, or that the patient had been miscategorised. It was explained that if it was unclear what category a case should be placed in at the time a call was taken they would always be placed in the higher category.

During discussion members queried whether an increase in service had been seen due to the recent heat wave. Tina Benson informed the Committee that Brent had been largely unaffected by the heat wave and due to good performance, had been able to assist other hospitals that were struggling to meet demand. In response to queries regarding the number of consultants at weekends, it was explained that this had not yet happened although an advert was placed seeking five consultants and hoped to have them in place by October to add support at weekends. In response to diverted ambulance en route to the maternity department, it was clarified that some ambulances are directed to go elsewhere either due to preference of pressures at the hospital. In response to queries regarding the new A&E department at Northwick park Hospital and whether this would require extra doctors, it was clarified that it was due to be completed in May 2014 and would be the same size but adjacent to the theatres and designed to improve flow creating efficiencies and increased nursing staff. In response to queries regarding high ED users, it was explained that a group had been established to review the data and governance arrangements with work being undertaken with GPs regarding the top 2000 callers and what action can be taken to stop them attending hospital where appropriate.

RESOLVED:

That the report be noted

6. **Pathology Incidents: Update**

Ian Winstanley, CCG, gave an overview of the governance and quality framework and the process undertaken. He highlighted that there were internal and external processes which the lab followed including external quality assurance testing and internal controls to assure results in the appropriate scales. Ian Winstanley drew member's attention to the local clinical assurance process overseeing three organisations and the regulatory framework clinical governance overview to assure quality of services.

Dr Patel informed the Committee that the application for accreditation for the service had been sent off and was currently awaiting appropriate resource from the accreditation authority to visit the pathology service and highlighted that a detailed response from TDL had been sent to the Chair of the Health Partnership Overview and Scrutiny Committee. Members highlighted the response at the previous Committee implying that the service had been accredited. It was clarified that at the last Committee they were under the impression that the accreditation was completed however subsequently they had received information that it was still awaiting inspection. Rob Larkman explained that TDL was an accredited company and for a local service to become accredited it first had to go live. Members expressed concern that a major incident had occurred and that the service may not be safe or effective and despite the service being in place since May 2012, accreditation had not been obtained. Dr Patel said he would resend a copy of the response regarding the TDL framework to the Chair. Members expressed concern about monitoring of the service and queried what had been done to improve monitoring. Dr Patel acknowledged that the monitoring was not robust enough and following a meeting with TDL and hospital consultants robust monitoring was put in place. As a consequence of the incident a national issue was highlighted regarding the reporting and changes were being made nationally as a result. It was explained that discussions were taking place with the client to explore what options were available for temperature controlled transportation of conveyancing samples. Members continued to express concern that the service was not yet accredited and requested that the item be brought back to the next Committee. Ian Winstanley invited members to visit the lab to see how it functioned and to alleviate concerns.

RESOLVED:

(i) That members noted the report
(ii) That the item be placed on future agendas until accreditation was secured

7. **Central Middlesex Hospital UCC Incident: Update Report**

Ian Winstanley, CCG, informed members that following the X-ray incident in October 2012, the provider had been contacted to ensure that all patients potentially affected had been located and contacted. He was pleased to inform the Committee that the remaining 11 patients had been contacted and the incident could be formally closed. During discussion it was noted that approximately 30 cases needed further investigation. It was clarified that no additional funding had been provided to the company to carry out the investigatory work and it was clarified that no other service had been affected by the potential reallocation of

budgets by the provider. Following concerns that the public purse may have been used to carry out the investigatory work; Ian Winstanley offered to invite the providers to a future meeting. Members requested that a short report be provided for the next meeting confirming whether further treatment had been required by any of the affected patients and what improvements had been made to the monitoring of the contract.

RESOLVED:

(i) Members noted the report
(ii) That an update report be provided at the next meeting

8. **Healthwatch Progress Update**

Ann O'Neill, Health Watch Brent, provided an update to the Committee on recent activity including getting up and running, membership, community engagement and relationship building. It was noted that although community directors had now been elected, they were taking steps to get a young director and to involve younger people in general. Ann O'Neill reported that work was being undertaken on gathering views at outreach meetings and it was felt that although there was a lot happening in the health service, the public were not aware of it. Issues were reported on a particular GP centre, audiology service and dementia service and it was noted that further work was required regarding each of these areas. Healthwatch Brent hoped to hold a focus group regarding the CQC consultation with the aim of making residents feeling comfortable and able to report and issues or concerns that they have regarding health providers. Ann O'Neill informed the Committee that the membership had now increased to 60 with the next steps requiring the recruitment of a coordinator; provide training at the end of August or September and to build links with other HealthWatch organisations.

During discussion members queried whether a diverse range of people were getting involved at various outreach meetings. It was explained that members tended to be over 30 years old although specific information was not available for the meeting. During discussion it was explained that the website was a standard template provided by Healthwatch England and was proving difficult to customise. It was noted that the director biographies were currently being uploaded and that they hoped to have the website completed by mid September.

RESOLVED:

That the report be noted

9. **Health Partnerships Overview and Scrutiny work programme 2013-14**

The Chair invited members of the Committee to comment on the work programme.

RESOLVED:

That the following items to added:

(i) Access to GPs – Current and future
(ii) Current diabetes services and future commissioning

10. **Any Other Urgent Business**

In response to queries as to whether Brent was going to submit a response in relation to the Independent Reconfiguration Panel regarding the Shaping Healthier Futures initiative it was confirmed that the Leader of the Council had sent a response.

The Chair informed the Committee that she had requested information regarding the cost of interim/agency staff on the NHS and confirmed a cost of £24,000 per month. The Chair requested details of how many of the interim staff were managers. It was clarified that names could not be provided but the CCG would collate a list of posts. Sarah Mansuralli explained that it had been previously difficult to recruit to senior roles and was pleased to informed the Committee that recruitment of two senior posts would commence this week with a further two posts to follow.

11. **Date of Next Meeting**

RESOLVED:

It was noted that the next scheduled meeting would take place on 8 October 2013.

The meeting closed at 9.15 pm

M DALY
Chair

Brent	**Health Partnerships Overview and Scrutiny Committee 8th October 2013** **Report from Assistant Chief Executive**
For Action	Wards Affected: ALL

GP and Primary Care Access and Service Provision

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that access to GPs remains an issue for many residents in Brent. Following the publication of the 2012/13 GP Patient Survey in June, NHS England and Brent CCG have been asked to report on these results and the wider issue of GP access and service provision in Brent.

1.2 The NHS England report outlines the general services provided by GPs under different contract types and summarises the contractual arrangements with GPs in Brent and the differing levels of access available at different practices across Brent. The report outlines the options and powers available to NHS England to deal with practices where there are concerns (not just with access) and gives NHS England's immediate plans for identifying and addressing practices where improvement may be needed.

1.3 The second report outlines the aims of the former ACE programme undertaken in 2010/11, by the PCT, designed to improve GP access. It gives a brief analysis of the trends over time on three key indicators from the patient satisfaction survey. It outlines the steps the CCG' have taken to improve GP access since being in shadow form in 2012, including Practice Improvement Plans, Peer Reviews and financial incentives. The report explains some of the barriers faced in meeting demand as well as the CCG's plans to increase overall capacity by commissioning additional evening and weekend appointments at five locality centres. Also outlined are the CCG's plans for developing Out of Hospital service including;

- development of integrated care networks based around GPs;
- commissioning of Out of Hospital services from GPs;
- workforce development;
- investment/development of primary care hubs;
- development of Out of Hospital Standards.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to question officers from NHS England and Brent CCG on the content of the reports and the GP access survey, including how their plans for dealing with poorly performing GP practices their strategic plans for improving/increasing GP access and service provision.

Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

Cathy Tyson
Assistant Director of Policy
Tel – 020 8937 1045
Email – cathy.tyson@brent.gov.uk

Access to Primary Medical Services in Brent

1. Roles and Responsibilities with regards to primary medical care commissioning.

1.1 The national GP Patient Survey (GPPS) for 2012-13 was published in June 2013. Brent Health Overview and Scrutiny Committee have requested a report from NHS England in relation to the survey results for Brent with specific reference to the questions on access to GP services.

1.2 This report sets out;

- NHS England's role of commissioning primary care and the contract forms used.
- The contractual requirements placed on practices with regards to access to services.
- A summary of the access elements of the national GPPS for Brent practices and service provision information.
- The tools available to NHS England to use to improve access to services and primary care services in general.
- The approach that will be taken by NHS England to address concerns about service provision or performance of primary care contractors.
- Appendices showing the provision of additional, enhanced and out of hours services and a copy of the standard General Medical Services (GMS) contract.

1.3 A separate report is being provided by Brent Clinical Commissioning Group (CCG) with an analysis of the recent survey results, progress to date and plans the CCG have in place for further improvement.

1.4 The theme that is of greatest concern, which is highlighted by the national GPPS results for Brent that is also mirrored across London, is the variation between practices in both the satisfaction with services and the levels of service provision.

2. Roles and Responsibilities with regards to primary medical care commissioning.

2.1. Contractual management of primary medical services is the sole responsibility of NHS England Area team (for Brent this is the North West London Area Team). However, delivery of effective, safe and high quality primary medical services requires CCGs to play an active role in supporting NHS England to drive improvements in primary care.

2.2. CCGs have a statutory duty to assist NHS England in the quality improvement of primary medical services and have an active interest in doing so for the effective delivery of their overall commissioning strategy. CCGs are also responsible and

accountable for services commissioned locally through the standard NHS contract.

3. Contractual Context

3.1. There are three types of contracts that NHS England holds with providers of primary medical services; General Medical Services Contracts (GMS), Personal Medical Services (PMS) contracts and Alternative Provider Medical Services (APMS) Contracts

3.2. GMS arrangements are governed by the GMS Regulations. These are based on national agreement between the Department of Health and the British Medical Association. Appendix One to this report provides the model GMS contract. 50 of Brent GP practices hold this type of contract.

3.3. PMS arrangements are an alternative to GMS, in which the contract is agreed locally between the contractor and NHS England. The mandatory contract terms are set out in the PMS Regulations, but still allow local flexibility for negotiation. 12 Brent practices hold this type of contract.

3.4. The mandatory requirements that apply to APMS contracts are set out in the APMS Directions 2010. These Directions place minimum requirements on APMS contractors which broadly reflect those for PMS contractors but otherwise enable the remainder of the contract to be negotiated locally. There are 5 APMS contracts in Brent.

3.5. All contractors who have a list of registered patients must provide *essential services.* Essential services are defined as services required for the management (including consultation, examination, investigation and referral) of registered patients and temporary residents who are, or believe themselves to be;

a) ill, with conditions from which recovery is generally expected;
b) terminally ill; or .
c) suffering from chronic disease,

3.6. The majority of practices in Brent also provide additional services, such as minor surgery, maternity services, cervical screening, childhood immunisations and vaccinations.

3.7. All practices also participate in the Quality and Outcomes Framework which financially rewards practices for meeting a range clinical and organisational performance standards.

3.8. Appendix Two provides a summary of the additional and enhanced services provided by Brent practices (please note that we are still receiving applications from practices to provide enhanced services for this financial year, therefore this list is incomplete).

4. Requirements of the contract in relation to Access

4.1. All providers of essential services are required under the contract to provide primary medical services to their patients at such times as are appropriate to meet the reasonable needs of its patients, and to have in place arrangements for its patients to access such services throughout the *core hours* of 8am - 6.30pm, Monday to Friday, in case of emergency.

4.2. Patients are expected to be able to access primary care services either face to face or via phone to receive clinical advice, book appointments, follow up referral letters, change or collect prescriptions etc. GPs are also expected to be available during contracted hours (8 am to 6.30pm) to follow up patient care, liaise with other clinical services and provide emergency care.

4.3. The GMS contract does not explicitly stipulate a minimum period that a practice premises has to be open, or a maximum time a patient should expect to wait for an appointment. However, practices that close during core hours are expected to make alternative arrangements for their patients to access primary medical care during that time. Often practices make arrangements with out of hours providers during these times.

4.4. There are currently no national incentive schemes or performance targets related to access to GP services within core hours. Nevertheless, NHS England believes that it is reasonable to expect practices to offer a routine appointment with a GP within 2 days as well as the ability to book appointments in advance.

4.5. Practices that hold PMS contracts have the same basic requirements as mentioned in 3.1 above. They may also have further requirements stipulated in their contracts to open at specific times or outside of core hours.

4.6. APMS contract holders will often have minimum opening times stated explicitly within their contract (8-6.30 as a minimum), as well as performance measures requiring them to offer appointments within certain timescales (e.g. same day appointments or routine appointments within 48 hours).

4.7. All practices offer home visits for patients who are deemed unable to attend the practice premises and, indeed, they are contractually obliged to do so.

5. Access in Brent

Opening hours

5.1. In the national GP Patient Survey (GPPS) 74% of patients registered with a Brent GP reported they were satisfied with the opening hours of their surgery, compared to a national average of 80%. Between Brent practices the satisfaction with opening hours varies significantly between 54% and 96%. 69% of patients reported that they would like to be able to see or speak to a GP or nurse on a Saturday.

5.2. An analysis of opening hours of Brent practices demonstrates that opening hours within core hours (8am-6.30pm) varies. There are 5 practices that are open for the full core hours period and 64% close for 2 hours or less a day within core

hours (this doesn't include practices who close for a half day one day during the week).

5.3. Just under a quarter of practices are closed for more than 2 hours over the lunchtime period and 70% of practices close early (before 5pm) at least one day per week.

5.4. 76% of practices (50/67) deliver consultation times outside of the core hours by opting in to deliver the Extended Hours Direct Enhanced Service (DES) agreement. This DES is a national scheme to offer access outside core hours. The majority of practices deliver this service early in the mornings before 8am or after 6.30pm on a weekday. 6 practices deliver extended hours at weekends.

Length of time to see a GP or nurse

5.5. The survey shows that 86% of patients in Brent who had tried to get an appointment were able to, compared to 90% nationally. Amongst Brent practices this ranges from between 99% to 71% of patients reporting that they were able to get an appointment with a GP.

5.6. For those patients who were unable to get an appointment or who were offered an appointment that was inconvenient for them, 65% either went to the appointment or got an appointment for a different time. However 14% reported that they went to A&E or a walk-in centre instead. Again this varies significantly between practices; in one Brent practice, of the patients reporting that were unable to get an appointment, 42% of them reported that they went to A&E or a walk-in centre.

Telephone access

5.7. Ease of getting through to the practice on the telephone also varies significantly at a practice level; this ranges from 41% to 96% of patients reporting it as easy to get through on the phone.

Clinical capacity

5.8. Lack of clinical capacity can be an important element in understanding problems in GP access. Brent has a relatively high GP per patient ratio with one GP per 1700 patients. This will vary amongst practices however.

5.9. In addition Practice Nurse and Healthcare Care Assistant (HCA) support is vital to support good access in a practice. Practice nurses commonly are able to treat small injuries, perform health screening, support family planning, run vaccination and health protection programmes (for example flu or stop smoking) and support long term conditional management. Healthcare Assistants are able to help with washing and dressing wounds, monitoring patients' conditions by taking temperatures, pulse, respirations and weight and often are able to take blood.

5.10. At the last national practice staff survey (October 2012) 64 of 66 Brent practices reported that they had a practice nurse and over half have a HCA. However, there is significant variation amongst practices in the number of hours of

nurse/HCA time a practice has. The national survey for 2013 is taking place now which will show more up to date staffing data.

6. Tools and levers for improving access

6.1. The analysis above demonstrates that many practices are providing a high level of service to patients and are meeting patient expectations. However there is significant variation in both patients experience of accessing GP services and the service provided by GPs. This variation is mirrored across England.

6.2. There are several tools and levers that NHS England can use to address unsatisfactory levels of service provided by practices. The interventions used by NHS England will depend on the level of concern there is about a practice, and will range from asking CCGs to facilitate improvement through networks and peer support, to using contractual levers to compel action by the practice.

6.3. The national Assurance Framework developed by NHS England, pulls together a range of demographic and performance information about practices. A key element of this is patient reported satisfaction of accessing GP services, as well as comparative data on A&E attendance and admissions.

6.4. NHS England will use this tool, along with other information about the practice such as clinical capacity, complaints and patient feedback and Care Quality Commission (CQC) reports, to identify and manage practices where there are concerns about the level of service provided and its quality.

6.5. NHS England will decide upon the most appropriate intervention, often having worked with CCG colleagues to ensure practices are provided support and guidance to improve.

6.6. Where it is believed that the level of service provided by a practice is inadequate to meets its contractual obligations and the practice is not demonstrating improvements, NHS England will use contractual levers, such as breach notices and contract sanctions to drive improvements to services.

7. Next Steps

7.1. The main concern highlighted by this data on access to GP services is the variation in the levels of patient satisfaction and of the services provided between Brent practices.

7.2. As the commissioners of primary care, NHS England will identify practices with the poorest levels of satisfaction and service provision. Then as part of our programme of assurance and performance management, we will review other key performance information held about those practices. This will reveal if there are any broader concerns relating to performance or compliance at those practices. Using this information we will approach practices and require them to produce a performance improvement plan, particularly where access is not the only indicator of concern. Improvement plans will be regularly monitored to ensure improvements are being implemented.

7.3. NHS England will work closely with Brent CCG to ensure practices are supported to improve and where area wide improvements might be needed, to ensure that the CCG puts assurance plans in place.

Appendices

Appendix One: Standard General Medical Services Contract
Appendix Two: Additional and Enhanced Services provided by Brent practices in 2013/14.

NHS
Brent
Clinical Commissioning Group

Report to Health Partnerships Overview and Scrutiny Committee

8 October 2013

Supporting practice improvement and primary care development

1. Introduction

The paper from the NHSE sets out the respective roles of NHS England and Brent CCG in commissioning and improving primary care services. This paper informs the Committee on the outcome of the Access Choice and Experience (ACE) Programme that NHS Brent PCT undertook in 2010/11 to improve access to GP services and the work Brent CCG has undertaken since April 2012.

2. ACE Programme

Brent PCT's ACE programme supported practices in improving access by:

- Helping practices to measure the demand for their services compared to the appointments they had available (telephone lines available and staff available for booking appointments; measuring demand for times and days for appointments and whether they were able to meet them)
- encouraging practices to offer at least 72 appointments per week per 1000 patients registered with the practice
- helping practices to better match demand for appointments with spread of appointments throughout the week including the mix of "on the day/next day" appointments with appointments that could be booked further in advance.

Members have asked for an update on the outcome of patient satisfaction rates with GP access since the report to the Committee on 5 April 2011. We have updated the scores by locality for the following questions:

a. Ease of getting through on the phone

b. Able to get an appointment fairly quickly

c. How satisfied are you with the hours that your GP surgery is open

The format and frequency of the GP patient survey changed after 2010/11. Questions on ease of getting through on the phone and satisfaction with GP surgery opening hours did not change. Up to 2010/11, being able to see a doctor fairly quickly was defined as the same day or next two weekdays the GP surgery was open. Patients were also asked if they could book more than 2 days in advance. From 2011/12, patients were no longer asked about being able to book more than two days in advance. Patients were asked "were you able to get an appointment to see or speak to someone". We have compared the positive results to this question with "able to get an appointment fairly quickly.

The results for these three questions for Quarter 3 2009/10, Quarter 3 2010/11 and latest results for 2012/13 by practice by locality are attached in Appendix 1.

A summary of the results is set out below:

a. How easy is it to get through on the phone?

The results for England and Brent were:

	2009/10	2010/11	2012/13
England	68%	69%	75%
Brent	61%	63%	71%

For Brent there has been a 10% improvement in the number of patients who have reported satisfaction in getting through on the phone. This was the area of greatest improvement achieved through the ACE programme. The greatest improvement was in Kilburn, with all practices improving, but in all localities at least 75% or more of practices improved. Kingsbury had the lowest percentage of practices that met national satisfaction levels.

Key points to note by locality are:

Harness
12 practices out of 16 have improved since 2009/10 (75%). Nine practices are above the national average in 2012/13 (56%). Four practices' satisfaction rates are well below the national average with little change since 2009/10.

Kilburn
All 15 practices have improved since 2009/10 (100%). Nine practices are at or above the national average (60%) and six are below the national average. One of these practices has since closed.

Kingsbury
12 out of 14 practices have improved since 2009/10 (86%). Two practices have not improved and only three practices reach the national average of 75% (21%).

Wembley
13 out of 15 practices have improved since 2009/10 (87%). One practice merged with another practice in 2012/13 so separate scores are not available for this practice. Seven out of 14 practices meet or are above the national average of 75% (50%). Two practices moved to Kingsbury locality in 2012/13: Premier Medical Centre and Beechcroft Medical Centre. Their scores have been retained in the Wembley table.

Willesden
8 out of 10 practices have improved since 2009/10 (80%). Two practices did not improve in this period. Six practices are above the national average (60%).

b. Able to get an appointment fairly quickly

	2009/10	2010/11	2012/13
England	80%	79%	86%
Brent	74%	73%	81%

The gap between England reported satisfaction in getting an appointment quickly and those reported in Brent has reduced from 14% to 5% with a 7% improvement in reported satisfaction between 2009/10 and 20012/13. There was some improvement in all localities ranging from 56% to 80% of practices. Harness had the lowest percentage of practices with national average scores or above in 2012/13.

Harness
Nine out of 16 practices have improved since 2009/10 (56%). Satisfaction in ability to get an appointment fairly quickly fell in six practices. Three practices are on or above the national average (19%).

Kilburn
Twelve out 15 practices have improved since 2009/10 (80%). Three practices did not improve but two of these are above the national average. Five practices are on or above the national average (33%).

Kingsbury
Eight out of 14 practices have improved since 2009/10 (57%). Six practices did not improve but one is above the national average. Four practices are on or above the national average (29%).

Wembley
Ten out of 14 practices have improved since 2009/10 (71%). Four practices did not improve. Five practices are on or above the national average (36%)

Willesden
Six out of 10 practices have improved since 2009/10 (60%). Four practices did not improve but one is above the national average. There are three practices above the national average (30%).

c. How satisfied are you with the hours that your GP surgery is open

	2009/10	2010/11	2012/13
England	81%	81%	80%
Brent	75%	75%	74%

Brent mirrors the satisfaction in GP surgery opening hours in that there has been a slight reduction in satisfaction between 2009/10 and 2012/13. There was less improvement in satisfaction in opening hours than in the other two questions with improvement ranging from 29% to 63%. Kingsbury and Willesden had the lowest percentage of practices who scored at or above the national average.

Harness
Ten out of 16 practices improved satisfaction scores since 2009/10 (63%). Nine scored at or above the national average (56%).

Kilburn
Seven out of 15 practices' satisfaction score have improved since 2009/10 (47%). Two that did not improve scored above the national average. Six practices are above the national average (40%).

Kingsbury
Only four practices' satisfaction scores improved (29%). In 2012/13, two practices scored above the national average score (14%).

Wembley
Six out of 14 practices satisfaction scores improved since 2009/10 (43%). In 2012/13, three practices were at or above the national average (21%).

Willesden
Three practices' satisfaction scores improved since 2009/10 (30%). Two practices meet or exceed national satisfaction scores (20%).

3. Brent CCG Support to Improving Primary Care

Brent CCG began operating in shadow form in April 2012 and developed the following strategies to support improvements in primary care:

i) supporting development and implementation of practice improvement plans

ii) investing in additional primary care capacity

iii) transforming primary care as part of developing out of hospital services.

3.1 Practice Improvement Plans and Peer Review

In 2012, practices were invited to develop individual practice improvement plans related to areas where they performed less well in the GP patient survey and in the NHS London GP outcomes framework for example the identification and management of patients with long term conditions. All practices developed improvement plans that were approved by their locality. If practices' chosen patient satisfaction scores and outcomes improve compared to 2011/12, the practice will receive a non recurrent financial reward to invest in their practice in 2013.

In addition, the CCG has worked with practices to ensure they were fully compliant when they registered with CQC in April 2013. This involved mock reviews, prompting corrective action plans.

In 2012/13 and 2013/14, the CCG has invested £500,000 per annum to improve practice premises in areas such as control of infection and accessible premises for people with disabilities. The CCG has continued to fund control of infection advice and access to specialist training and support for child and adult safeguarding.

As part of the delegated commissioning budget to localities, practices review each others:

- Referrals to hospital outpatients to ensure that patients are referred appropriately
- Patient usage of urgent care centres and accident and emergency departments
- Effective prescribing
- Patient emergency admission to hospital.

Where a practice's performance is different to their peers, a greater understanding of the difference in the practice population will be sought and if necessary the practice will develop an improvement plan. Progress against the plan will be reviewed by their peers.

3.2 Investing in additional capacity

As can be seen from the reported impact on the ACE programme, less progress was made on improving satisfaction with GP opening hours. Additional funding to increase GP opening hours has been limited to the extended hours direct enhanced service which is often one additional evening or Saturday session per week with booked appointments only. In the GP survey, patients have expressed preference for more surgeries in the evenings and at weekends.

Practices struggle to meet all demands made upon them as:

- Patients are discharged more quickly from hospital inpatients and outpatients with more complex conditions
- Patients seen in practice increasingly have more than one long term condition and their long term condition is more advanced
- Patients expect to be seen by a GP for the management of minor ailments as well as urgent serious conditions and the management of long term conditions

- Premises are often cramped and overcrowded and there is insufficient space to provide additional services even when NHSE or the CCGs wants to commission additional services
- Practices are largely funded on a capitation basis, ie £ per head of patients registered with the practice, not on activity like many other NHS providers who are paid more for the more they do
- Practice real income falls year on year so it is difficult to provide additional services.

In order to increase capacity in primary care and to improve patient satisfaction scores, Brent CCG is commissioning additional bookable appointments via a patient's GP practice in five locality centres on a pilot basis for six months. GP and nurse appointments will be available from 3 pm to 9 pm Monday to Friday and 9.00 am to 9 pm on a Saturday. These appointments are available now in the following localities:

Harness (from 2 September 2013)	Brent GP Access Centre, Wembley Centre for Health Monday to Friday Hilltop Medical Centre, Hillside Primary Care Centres Saturday
Kilburn (from 2 September 2013)	Kilburn Park Medical Centre Monday to Wednesday Staverton Surgery Thursday to Saturday
Willesden (from 23 September 2013)	Burnley Practice, Willesden Centre for Health and Care

Expressions of interest were considered for hosting locality services from existing practices in Wembley and Kingsbury but contracts could not be awarded in July. Further expressions of interest were sought and received in September and these will be evaluated by a panel including lay member, NHSE and Healthwatch Brent representation on 25 September. Subject to award of contracts, we would expect locality services to be available from early November 2013.

The pilots will be evaluated against agreed outcomes by external assessors. If found successful longer term contracts will be awarded. We would want locality services to work closely with practices in the locality so that both the patient and the practice regard the locality service as an extension of the patient's practice, providing continuity of care.

The CCG did not pilot additional hours in individual practices as this would not have represented value for money and would have been difficult to distinguish from the services commissioned by the NHSE. The CCG will ensure that during the pilots, GP practices continue to provide the current capacity within their practice.

3.3 Developing Out of Hospital Services

Transforming primary care is essential to the success in developing out of hospital services in line with Brent CCG's strategy. Brent CCG is working with the eight CCGs on a number of workstreams to transform primary care. These include:

i) Developing integrated networks of care with GP services at the centre of patient's care

ii) Commissioning out of hospital services from GPs

iii) Developing the workforce to support primary care

iv) Seeking investment from NHSE on outline business cases for hubs for primary care and community services and investment in GP premises

v) Developing Out of Hospital standards

i) Developing integrated networks of care with GP services at the centre of patient's care

Brent GPs are already involved in the Outer North West London Integrated Care Pilot where GPs work with hospital consultants, community professionals and social care in developing individual care plans for patients with diabetes and older patients with complex needs. The pilot has now been extended to include all patients who could benefit from multidisciplinary care.

Brent CCG is supporting all five localities to develop a locality GP vehicle in which staffing and premises can be shared so that the range and quality of services can be extended. We plan to commission community services such as specialist nurses and district nursing to support teams around the five localities. Our plan for integrated networks of care is that we better anticipate patients' needs for care and support them when coming out of hospital.

ii) Commissioning out of hospital services from GPs

In 2013/14, CCGs have continued to commission local enhanced services from practices. A list of current enhanced services commissioned by the CCG is attached at Appendix 2. The CCG cannot commission any new local enhanced services and from April 2014 must commission all out of hospital services through an NHS contract. NW London CCGs are working together to develop criteria for determining those services which should be list based and only available to practices and those which any health provider could provide and be subject to competition.

iii) Developing the workforce to support primary care

As can be seen from the NHSE report, limited information is known about the workforce in GP practices. Localities have undertaken a number of skills audits to support development of primary care services and provide training. However a more intensive and coordinated approach is required to support delivery of the CCGs' Out of Hospital Strategies. The NW London CCGs will start this work with a baseline assessment of the workforce in primary care.

iv) Seeking investment from NHSE on outline business cases for hubs for primary care and community services and investment in GP premises

As part of *Shaping a Healthier Future* and Brent CCG's Out of Hospital Strategy, Brent CCG identified the need for three hubs for primary and community services: Central Middlesex Hospital, Wembley and Willesden Centres for Health. In addition the CCG identified the need for locality centres at Kingsbury and South Kilburn. NHSE has approved the funding to support the Kingsbury locality centre. The CCG with support from the NW London Strategy and Transformation Team will be developing outline business cases for CMH as a hub plus with specialist diagnostic services, outpatients and GP services and extended community services at Willesden and Wembley. A final business case will be developed for South Kilburn. Localities will be asked to develop plans for their networks that will also include the need for premises developments for individual practices.

iv) Developing Out of Hospital standards

The eight NW London CCGs are developing outcomes and standards that all Out of Hospital providers are required to meet including general practice. New service contracts and investment in premises are likely to be only awarded to practices who meet outcomes and standards agreed by the eight CCGs. Draft standards are being developed based on the Standards consulted upon in Shaping a Healthier Future.

Consultation with practices will be required and CCG Governing Bodies will need to approve the standards. Appendix 3 sets out the categories of outcomes and standards that will be developed.

Appendix 1

Appendix 2

Appendix 3

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Appendix 1 Brent CCG Primary Care Improvement

Harness GP Consortia GPPS comparitive results Qtr 3 09/10 to Qtr 3 10/11	Ease of getting through on the phone Qtr3 09/10	Ease of getting through on the phone Qtr3 10/11	Ease of getting through on the phone. Qtr 3 2012-13.	Able to get an appointment fairly quickly Qtr 09/10	Able to get an appointment fairly quickly Qtr 3 10/11	Able to get an appointment fairly quickly. Qtr 3 2012-13.	Satisfied with opening times Qtr 3 09/10	Satisfied with opening times Qtr 3 10/11	Satisfied with hours GP surgery is open. Qtr 3 2012-13.
RESULTS FOR ENGLAND AS A WHOLE	**68%**	**69%**	**75%**	**80%**	**79%**	**86%**	**81%**	**81%**	**80%**
RESULTS FOR NHS BRENT	**61%**	**63%**	**71%**	**74%**	**73%**	**81%**	**75%**	**75%**	**74%**
THE CHAPLIN RD SURGER- PATEL	72%	81%	80%	87%	87%	79%	78%	75%	72%
BUCKINGHAM RD SURGERY	39%	64%	84%	97%	85%	87%	79%	83%	84%
ACTON LANE SURGERY	66%	72%	81%	83%	92%	78%	81%	84%	85%
FREUCHEN MEDICAL CENTRE	66%	71%	75%	76%	75%	84%	75%	76%	73%
THE SURGERY HARROW RD	65%	76%	86%	79%	81%	74%	77%	84%	86%
PARK ROAD SURGERY	67%	73%	85%	75%	77%	86%	73%	80%	80%
OXGATE GARDENS SURGERY	50%	56%	72%	74%	70%	75%	77%	78%	82%
AKSYR MEDICAL PRACTICE	60%	59%	57%	70%	64%	71%	72%	72%	55%
HARLESDEN HARNESS CARE	66%	68%	71%	63%	74%	72%	71%	83%	86%
CHURCH LANE SURGERY	63%	73%	71%	78%	81%	82%	76%	81%	80%
HILLTOP MEDICAL PRACTICE	64%	70%	90%	62%	56%	79%	77%	76%	75%
WEMBLEY PARK DRIVE MEDICAL CENTRE	60%	58%	55%	77%	70%	75%	79%	75%	61%
CHURCH END MEDICAL CENTRE	47%	44%	39%	73%	78%	73%	81%	81%	66%
BRENTFIELD MEDICAL CENTRE	49%	56%	80%	64%	67%	89%	85%	84%	91%
THE STONEBRIDGE MEDICAL PRACTICE	45%	27%	49%	49%	52%	66%	66%	81%	72%
BRENT GP ACCESS UNIT HARNESS-WEMBLEY	N/A	72%	74%	N/A	89%	71%	N/A	89%	92%

Key:
Green: Improved
Amber: No change
Red: Declined

Kilburn GP Consortia GPPS comparitive results Qtr 3 09/10 to Qtr 3 10/11	Ease of getting through on the phone Qtr3 09/10	Ease of getting through on the phone Qtr3 10/11	Ease of getting through on the phone. Qtr 3 2012-13.	Able to get an appointment fairly quickly Qtr 3 09/10	Able to get an appointment fairly quickly Qtr 3 10/11	Able to get an appointment fairly quickly. Qtr 3 2012-13.	Satisfied with opening times Qtr 3 09/10	Satisfied with opening times Qtr 3 10/11	Satisfied with hours GP surgery is open. Qtr 3 2012-13.
RESULTS FOR ENGLAND AS A WHOLE	**68%**	**69%**	**75%**	**80%**	**79%**	**86%**	**81%**	**81%**	**80%**
RESULTS FOR NHS BRENT	**61%**	**63%**	**71%**	**74%**	**73%**	**81%**	**75%**	**75%**	**74%**
THE WINDMILL MEDICAL PRACTICE	88%	88%	95%	94%	93%	92%	89%	86%	91%
THE SHELDON PRACTICE	75%	75%	76%	94%	97%	68%	85%	81%	63%
WILLESDEN GREEN SURGERY	80%	87%	85%	81%	85%	85%	84%	90%	84%
PEEL PRECINCT SURGERY	84%	88%	95%	83%	95%	86%	82%	90%	89%
THE CLARENCE MED CENTRE	74%	77%	85%	88%	85%	87%	83%	84%	76%
PARK HOUSE MEDICAL CENTRE	82%	81%	94%	72%	72%	77%	76%	80%	90%
CHAMBERLAYNE RD SURGERY	64%	61%	65%	72%	67%	80%	61%	59%	59%
CHICHELE ROAD SURGERY	61%	60%	75%	76%	86%	91%	75%	66%	70%
STAVERTON SURGERY	70%	74%	85%	65%	68%	84%	84%	80%	89%
THE LAW MEDICAL GROUP PRACTICE	57%	56%	58%	72%	73%	90%	76%	80%	74%
BLESSING MEDICAL CENTRE	47%	55%	64%	69%	70%	77%	59%	69%	74%
KILBURN PARK MEDICAL CENTRE	47%	39%	61%	65%	63%	83%	87%	78%	83%
THE LONSDALE MEDICAL CENTRE	50%	60%	65%	61%	72%	77%	69%	73%	74%
~~THE MEDICAL CENTRE now closed~~	55%	58%	62%	39%	46%	81%	71%	70%	61%
THE LEVER MEDICAL CENTRE	55%	61%	78%	46%	49%	75%	76%	71%	83%

Key:
Green: Improved
Amber: No change
Red: Declined

Kingsbury GP Consortia GPPS comparitive results Qtr 3 09/10 to Qtr 3 10/11	Ease of getting through on the phone Qtr 3 09/10	Ease of getting through on the phone Qtr 3 10/11	Ease of getting through on the phone. Qtr 3 2012-13.	Able to get an appointment fairly quickly Qtr 09/10	Able to get an appointment fairly quickly Qtr 3 10/11	Able to get an appointment fairly quickly. Qtr 3 2012-13.	Satisfied with opening times Qtr 3 09/10	Satisfied with opening times Qtr 3 10/11	Satisfied with hours GP surgery is open. Qtr 3 2012-13.
RESULTS FOR ENGLAND AS A WHOLE	**68%**	69%	**75%**	**80%**	79%	**86%**	**81%**	81%	**80%**
RESULTS FOR NHS BRENT	**61%**	63%	**71%**	**74%**	73%	**81%**	**75%**	75%	**74%**
UXENDON CRESCENT SURGERY	79%	78%	79%	87%	88%	90%	81%	83%	71%
BRAMPTON HEALTH CENTRE	77%	82%	78%	88%	76%	76%	61%	66%	47%
PRESTON ROAD SURGERY	77%	83%	71%	85%	85%	80%	86%	87%	76%
THE TUDOR HOUSE MEDICAL CENTRE	71%	78%	90%	95%	84%	96%	85%	79%	83%
THE FRYENT WAY SURGERY	72%	64%	74%	81%	77%	80%	77%	71%	68%
WILLOW TREE FAMILY DOCTORS	64%	65%	67%	80%	83%	86%	80%	80%	83%
PRIMARY CARE MEDICAL CENTRE	65%	62%	61%	91%	88%	87%	80%	81%	70%
FRYENT MEDICAL CENTRE	49%	55%	65%	85%	84%	77%	77%	77%	76%
ELLIS PRACTICE	66%	56%	68%	90%	92%	84%	83%	85%	85%
FORTY WILLOWS SURGERY	56%	64%	67%	78%	79%	80%	79%	84%	76%
CHALKHILL FAMILY PRACTICE	67%	71%	72%	64%	61%	76%	77%	78%	73%
STAG LANE MEDICAL CENTRE	36%	39%	55%	66%	70%	69%	57%	68%	65%
THE STAG-HOLLY ROAD SURGERY	30%	32%	70%	46%	48%	81%	57%	58%	68%
KINGS EDGE	35%	30%	58%	65%	66%	75%	58%	57%	60%

Key:
Green: Improved
Amber: No change
Red: Declined

Wembley GP Consortia GPPS Comparitive results Qtr 3 09/10 to Qtr 3 10/11	Ease of getting through on the phone Qtr 3 09/10	Ease of getting through on the phone Qtr3 10/11	Ease of getting through on the phone. Qtr 3 2012-13.	Able to get an appointment fairly quickly Qtr 3 09/10	Able to get an appointment fairly quickly Qtr 3 10/11	Able to get an appointment fairly quickly. Qtr 3 2012-13.	Satisfied with opening times Qtr 3 09/10	Satisfied with opening times Qtr 3 10/11	Satisfied with hours GP surgery is open. Qtr 3 2012-13.
RESULTS FOR ENGLAND AS A WHOLE	**68%**	**69%**	**75%**	**80%**	**79%**	**86%**	**81%**	**81%**	**80%**
RESULTS FOR NHS BRENT	**61%**	**63%**	**71%**	**74%**	**73%**	**81%**	**75%**	**75%**	**74%**
PRESTON MEDICAL CENTRE	85%	91%	95%	96%	94%	98%	88%	86%	87%
SMS MEDICAL PRACTICE	71%	80%	87%	75%	80%	90%	73%	73%	80%
PREMIER MEDICAL CENTRE	67%	73%	70%	64%	76%	87%	70%	76%	76%
LANFRANC MEDICAL CENTRE	83%	86%	89%	92%	87%	88%	84%	72%	80%
THE EAGLE EYE	71%	71%	81%	83%	76%	86%	67%	63%	68%
THE SURGERY GP UNIT	67%	75%	n/a	81%	92%	n/a	73%	75%	n/a
SUDBURY COURT SURGERY	55%	48%	52%	89%	81%	78%	78%	78%	72%
SUDBURY & ALPERTON MEDICAL CENTRE	45%	41%	64%	89%	87%	85%	78%	78%	68%
KENTON MEDICAL CENTRE	65%	68%	66%	85%	87%	100%	74%	69%	64%
STANLEY CORNER MEDICAL CENTRE	53%	60%	80%	78%	79%	75%	79%	80%	75%
THE BEECHCROFT MEDICAL CENTRE	50%	50%	55%	78%	69%	82%	81%	76%	55%
LANCELOT MEDICAL CENTRE	55%	66%	81%	65%	68%	71%	58%	60%	59%
HAZELDENE MEDICAL CENTRE	66%	62%	65%	51%	43%	63%	78%	77%	57%
THE SUNFLOWER MEDICAL CENTRE	51%	61%	68%	50%	52%	77%	71%	68%	73%
ALPERTON MEDICAL CENTRE	48%	56%	80%	56%	56%	72%	56%	64%	74%

Key:
Green: Improved
Amber: No change
Red: Declined

Willesden GP Consortia GPPS comparitive results Qtr 3 09/10 to Qtr 3 10/11	Ease of getting through on the phone Qtr3 09/10	Ease of getting through on the phone Qtr3 10/11	Ease of getting through on the phone. Qtr 3 2012-13.	Able to get an appointment fairly quickly Qtr 3 Qtr 09/10	Able to get an appointment fairly quickly Qtr 3 10/11	Able to get an appointment fairly quickly. Qtr 3 2012-13.	Satisfied with opening times Qtr 3 09/10	Satisfied with opening times Qtr 3 10/11	Satisfied with hours GP surgery is open. Qtr 3 2012-13.
RESULTS FOR ENGLAND AS A WHOLE	**68%**	**69%**	**75%**	**80%**	**79%**	**86%**	**81%**	**81%**	**80%**
RESULTS FOR NHS BRENT	**61%**	**63%**	**71%**	**74%**	**73%**	**81%**	**75%**	**75%**	**74%**
ST.GEORGES MEDICAL CENTRE	86%	88%	84%	78%	82%	74%	74%	78%	71%
THE VILLAGE MEDICAL CENTRE	64%	66%	81%	88%	91%	76%	76%	69%	69%
CREST MEDICAL CENTRE	65%	67%	91%	92%	97%	91%	76%	81%	80%
ROUNDWOOD PARK MEDICAL CENTRE	79%	86%	87%	78%	83%	87%	73%	80%	75%
WALM LANE SURGERY	76%	76%	83%	66%	71%	78%	73%	69%	61%
NEASDEN MEDICAL CENTRE GREENHILL	78%	71%	74%	87%	82%	68%	74%	75%	72%
BURNLEY PRACTICE	75%	73%	82%	68%	77%	83%	73%	77%	92%
ST ANDREWS MEDICAL CENTRE	54%	65%	67%	80%	79%	87%	71%	78%	66%
GLADSTONE MC	45%	57%	56%	50%	52%	73%	81%	79%	68%
THE WILLESDEN MEDICAL CENTRE	22%	18%	41%	59%	61%	78%	62%	62%	62%

Key:
Green: Improved
Amber: No change
Red: Declined

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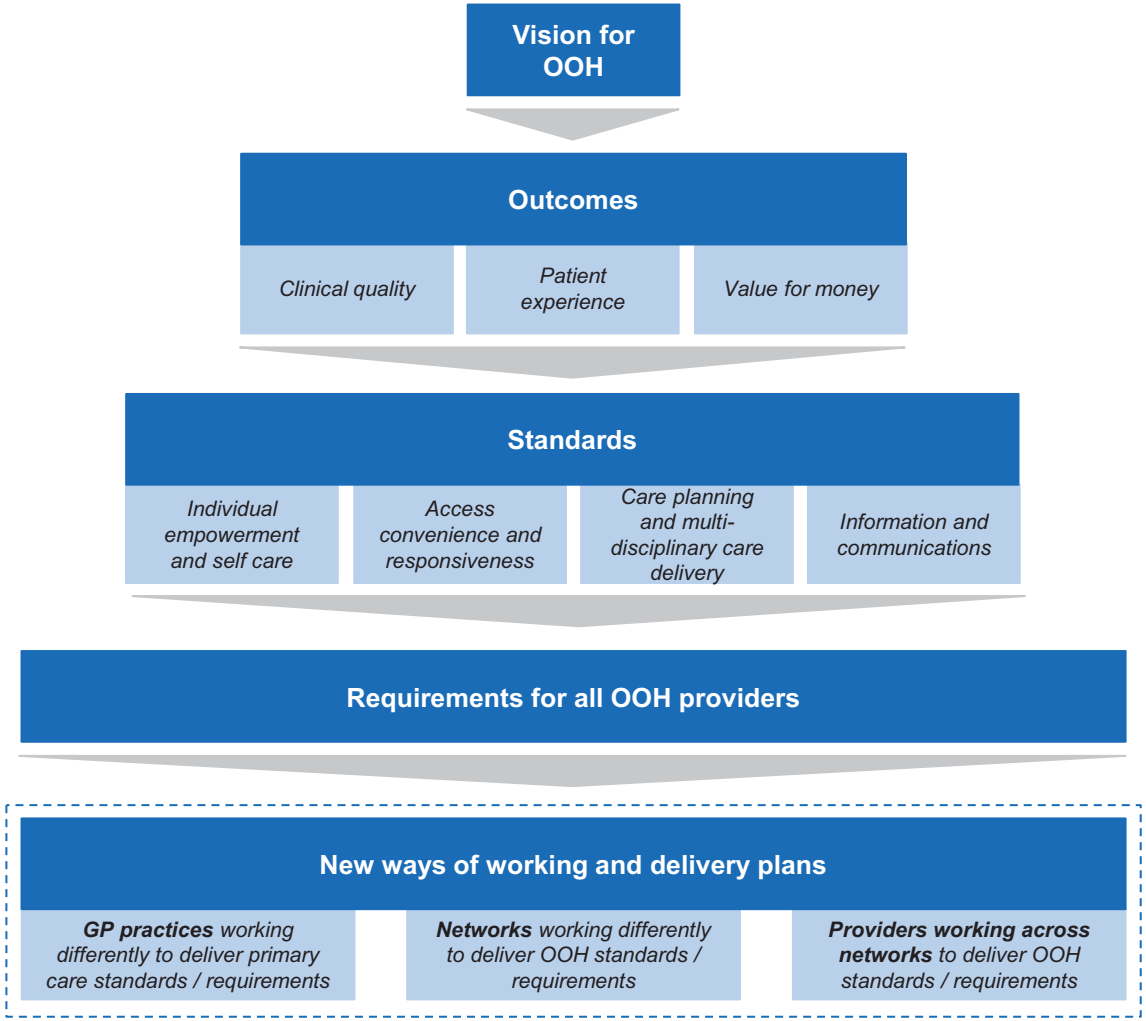
Appendix 2 Brent CCG Primary Care Improvement

LOCALITY	PRACTICE	GMS/PMS/APMS	Carers	Cardiology	IAPT	Zoladex	Phlebotomy	Diabetes Insulin	CHS	End of Life
Harness	Brentfield Medical Centre	PMS		Y	Y	Y		Y		
Harness	Buckingham Rd	GMS				Y	Y			
Harness	Church End Med Centre	PMS			Y	Y	Y			
Harness	Stonebridge Medical Centre	GMS	y			Y	Y			
Harness	260 Harrow road	PMS				Y	Y	Y		
Harness	Oxgate Gardens	GMS	Y			Y	Y	Y		Y
Harness	Wembley Park Med Centre	GMS	Y	Y	Y	Y	Y	Y		
Harness	Harness	APMS								
Harness	Aksyr Medical Centre	GMS					Y			
Harness	Church Lane Surgery	PMS				Y	Y			
Harness	Acton Lane Surgery	GMS					Y			
Harness	Freuchen Medical Centre	GMS			Y	Y	Y			
Harness	Hilltop Medical Practice	GMS				Y				
Harness	Park Road Surgery	GMS	Y			Y				
Harness	Pearl Medical Centre	GMS	Y							
Kilburn	The Lonsdale	GMS			Y	Y	Y			
Kilburn	Blessing Med Cntr (Obiekwe)	GMS	Y		Y	Y	Y			
Kilburn	Park House Med Cntr (Tooth)	GMS	Y		Y	Y	Y			
Kilburn	Kilburn Park Medical (Braunold)	GMS		Y			Y	Y		
Kilburn	Chichele Road Surgery	GMS			Y	Y				
Kilburn	Staverton Medical Centre	PMS	Y		Y	Y	Y	Y		
Kilburn	The Law Medical Group	PMS		Y	Y	Y		Y		
Kilburn	Willesden Green Surgery	GMS	Y			Y	Y			Y
Kilburn	Windmill Medical Centre	GMS					Y			
Kilburn	Peel Precinct Surgery	GMS								
Kilburn	Clarence Med Centre	GMS								
Kilburn	Chamberlayne Rd Surgery	GMS	Y			Y	Y	Y		Y
Kilburn	Lever Medical Centre	GMS	Y		Y					
Kilburn	Sheldon	GMS				Y				
Willesden	Gladstone Medical Centre	GMS	Y	Y		Y	Y			Y

LOCALITY	PRACTICE	GMS/PMS/APMS	Carers	Cardiology	IAPT	Zoladex	Phlebotomy	Diabetes Insulin	CHS	End of Life
Willesden	Walm Lane	GMS	Y			Y	Y			
Willesden	St George's medical centre	PMS				Y	Y			
Willesden	Neasden Medical Centre& Greenhill Park	GMS				Y	Y	Y	Y	
Willesden	Burnley Practice	APMS			Y	Y	Y		Y	
Willesden	Crest Medical Centre	GMS				Y				
Willesden	St Andrews Medical Centre	GMS				Y				
Willesden	Willesden	GMS		Y						
Wembley	Preston Medical Centre	GMS				Y	Y			
Wembley	SMS Medical Practice	GMS				Y	Y			
Wembley	Sudbury Surgery	APMS								
Wembley	Alperton	GMs	Y			Y				Y
Wembley	Haseldene Medical Centre	GMS	Y	Y	Y	Y				
Wembley	Sunflower Medical Centre	GMS				Y				
Wembley	Lancelot	GMS				Y				
Wembley	Stanley Corner Medical Centre	GMS			Y	Y				
Wembley	Lanfranc Medical Centre	PMS				Y				
Kingsbury	Forty Willows Surgery	GMS	Y	Y	Y	Y	Y	Y		
Kingsbury	Stag Lane Med Centre	GMS	Y		Y	Y	Y	Y		
Kingsbury	Premier Medical Centre	GMS	Y	Y		Y	Y			
Kingsbury	Kings Edge Medical Centre	PMS					Y	Y		
Kingsbury	Fryent Medical Centre	GMs	Y		Y	Y				Y
Kingsbury	Ellis	PMS	Y			Y				
Kingsbury	Primary Care Kenton	GMS	Y	Y		Y				Y
Kingsbury	Uxendon Medical Centre	GMS	Y	Y		Y				
Kingsbury	Fryent Way Medical Centre	GMS		Y		Y				
Kingsbury	Preston Road	PMS				Y				
Kingsbury	Beechcroft Medical Centre	GMS				Y				
Kingsbury	Stag Holly Road	GMS	Y							
Kingsbury	Willow Tree Family Doctors	PMS	Y			Y				Y

Cardiology	All surgeries on list above have signed up
Zoladex	All surgeries on list above have signed up
	Not signed up for LES
Y	Have submitted claims in the last quarter

The delivery plans for OOH are critical to delivering the vision and standards for OOH care



- Delivering the OOH strategy, and meeting expected standards / requirements, will require changes in how services are provided.
- This spans primary, community, mental health and social care. But in particular, changes will need to happen across GP practices.
- To enable GPs to make the changes they need to (e.g., offering enhanced access, care co-ordination or new services), networks are a critical enabler.
- These networks can support GPs to deliver OOH services and meet relevant standards and requirements.

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Brent	**Health Partnerships Overview and Scrutiny Committee 8th October 2013** **Report from Assistant Chief Executive**
For Action	Wards Affected: ALL

Brent CCG: Wave 2 Commissioning

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that Brent CCG has a duty to consult the committee on any substantial variation in the provision of any health services in Brent.

1.2 For its "Wave 2" commissioning, the CCG intends to commission the following services through competitive tendering: Musculoskeletal Services, Trauma and Orthopaedics, Rheumatology, Gynaecology. The report outlines the legislative framework and the CCG's general approach to commissioning along with brief details of its reasons for commissioning these services in Wave 2.

1.3 The report outlines the planned approach and timescale for the commissioning, including the early consultation stages. The CCG also intends to report back to the committee again in December or January to seek its views on the proposed service specifications for each of these services.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to question officers on the reasons and rationale for tendering these contracts in the way proposed.

2.2 The committee is also recommended to question officers further on the proposed consultation process to establish whether it is adequate.

Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

Cathy Tyson
Assistant Director of Policy
Tel – 020 8937 1045
Email – cathy.tyson@brent.gov.uk

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NHS Brent Clinical Commissioning Group

Report to:	Brent Health Partnerships Overview and Scrutiny Committee (OSC) Brent CCG Equalities, Diversity, and Engagement (EDEN) Committee
Report from:	NHS Brent CCG
Date of meeting:	8th October 2013
Re:	**Wave 2 Outpatient Procurement Commissioning Briefing**

1. Purpose of the Report

1.1 This report sets out the background to NHS Brent CCG's commissioning intention to commission outpatient specialities, the general procurement and consultation plans with respect to the specialities that will be commissioned as part of Wave 2 and the rationale which supports the decision to re-commission these services.

1.2 The report further outlines next steps and draft timescales with regard to this procurement and identifies the points at which there will be further updates on progress to the Health Partnerships OSC.

2. Background

2.1 The CCG's intention to commission new pathways for outpatient specialities originates from the PCTs Commissioning Strategy Plan (2009-14), which was subject to extensive consultation and engagement at the time of development, articulated the rationale for reviewing the way in which certain outpatient specialities were commissioned. The Commissioning Strategy Plan (CSP) 2009-14 highlighted that there were variable referral rates to acute care in some specialities, community pathways for elective care are under developed and that some pathways for elective outpatient care are fragmented across providers resulting duplication.

2.2 Subsequently, working in shadow form with GP Clinical Commissioners (following white paper on NHS Reforms[1]), NHS Brent PCT published a refreshed CSP, which reconfirmed GP Clinical Commissioning's intentions to review the way in which outpatient elective care is commissioned. This publication proposed a phased programme of change to implement and ambitious and innovative approach to the establishment of care pathways for identified specialities for elective care which:

- Supports care provided within general practice without the need for onward referral
- Transforms community provision including a multi-disciplinary team approach
- Reduces the need for onward referral to acute settings and decommissions consultations which do not currently add clinical value for patients.

2.3 This intention was re-emphasised by the Brent Shadow CCG Governing Body when it approved its corporate objectives in 2012-13. Corporate objective 3 – QIPP delivery

[1] Liberating the NHS white paper, Department of Health (July, 2010)

clearly defined the intention to re-commission 13 specialities in 'waves' with associated timescales for doing so.

2.4 As part of the authorisation process for CCG's to be established as statutory successors of PCT commissioning responsibilities, the CCG was required to produce an Integrated Plan (finance and commissioning intentions) which set out the CCG's commissioning intentions for 2013-14. This was subject to patient and public engagement with CCG representatives visiting several forums and holding a public event (14th November 2012) to consult on the integrated plan and commissioning intentions.

2.5 As the successor statutory organisation to NHS Brent PCT, the CCG inherits the assets, liabilities and commissioning plans that were developed by the PCT, jointly with clinical commissioners and in discussion with patients and the public that participated in the extensive consultation that supported the development of our commissioning plans to date.

3. Case for Change

3.1 NHS Brent CCG has emphasised that its mission is to:

- Commission services that improve the health and wellbeing of all patients registered with its member practices and those who are unregistered but are resident in the London Borough of Brent.

- Secure sustainable care that enables Brent patients to receive modern, responsive, high quality yet cost effective care

- Ensure that these services are effectively commissioned within the CCG's financial resource limits. NHS Brent CCG's mission is based on an aspiration to reduce health inequalities within the communities that make up Brent's diverse population.

3.2 There are three main challenges for Brent that mean how health care in the borough is delivered needs to change:

- The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care.

- Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital. This should provide better outcomes for patients, at lower cost

- However, this needs a transformation of primary, community and social care. Currently there is variation in both quality and access and standards must improve.

3.3 In order to achieve this and meet the needs of our population, it is not possible to maintain the current duplication and fragmentation which drains resources and does not offer high quality and cost effective care. There is much evidence from around the country that shows that we can commission outpatients services in the country at less cost and achieve better clinical outcomes.

3.4 The CCGs Out of Hospital (OOH) Strategy is a key enabler for the Shaping a Healthier Future (SaHF) programme. The success of SaHF is predicated on having substantial capacity in the community to meet population health needs, as described within Brent CCG's OOH Strategy. This is a fact that is well recognised by Brent Council in their

submission to the Independent Review Panel on Shaping a Healthier future (August 2013), which states that:

"SaHF makes it clear that changes to out of hospital care are essential if it is to deliver the planned changes to acute care. The general principle of transferring services from acute to community locations with investment in primary and community care, where appropriate, is welcomed. People should not have to travel to hospitals for routine care or to manage a long term condition."

3.5 Brent Council further express anxiety about failure to deliver CCG OOH strategies "*could have a knock on effect on neighbouring CCGs, particularly if it affects demand on shared acute care services"*. The submission further expresses concern that the Council has not seen any evidence of investment into out of hospital care.

3.6 NHS Brent CCG's Out of Hospital Strategy describes two key initiatives designed to improve how planned elective care is delivered; move some elective procedures from secondary to primary care and move a proportion of outpatient services to community settings. This is a key element of our OOH Strategy underpinning investment in community services and will determine the success of SaHF. Specifically, we anticipate that these initiatives will:

- Improve current quality of services
- Allow services to be provided in an integrated way, e.g. multi-disciplinary one stop shop
- Release funds for reinvestment into the increasing healthcare demands that the wider population are facing
- Allow us to develop innovative service models

3.7 The anticipated reduction in costs of commissioning these services is estimated in the table below. This will allow the CCG scope to reinvestment in healthcare that meets the growing demand of the wider public.

Wave 2

Outpatient Speciality	Gross full year efficiencies	Re-provision Costs in Community Services	Net Efficiencies
Musculoskeletal Services	MSK as a speciality along is unlikely to achieve any efficiencies; the purpose of procurement is to enable an integrated service with trauma, orthopaedics and rheumatology to improve quality of care and improved outcomes.		
Trauma & Orthopaedics	1,110	687	423
Rheumatology	480	336	144
Gynaecology	930	279	651
Totals	2,520	1,302	1,218

4. Approach to Procurement

4.1 In addition to these major strategic drivers for change, Brent CCG has a statutory duty to commission services for its population that:

- Continuously improves
- Ensures that expenditure does not exceed the allocated budget
- Are integrated and offer high quality care

4.2 To achieve the CCG's mission and fulfil its statutory obligations, the CCG has agreed to apply competitive procurement for services where there is:

- Poor provider performance
- Opportunity to commission more innovative models of care
- Opportunity to bring care closer to home in line with our vision and strategies
- Improve quality of care for patients
- Potential to achieve better value for money

4.3 In the case of wave two specialities, a combination of factors have resulted in a decision to re-commission these specialities. For rheumatology services there are no issues relating to poor provider performance but primary care have raised concerns about poor integration of MSK services. There is evidence nationally that more integrated MSK services which combine rheumatology, trauma and orthopaedics have improved clinical outcomes and achieve better value for money. This is a model that is being commissioned by many CCG's given its evidence base.

4.4 With respect to other specialities within wave 2, e.g. gynaecology there are comparatively lower rates of satisfaction with outpatients with the current provider and there is concern about the provider's ability to meet demand in view of recent breaches to the 18 weeks RTT NHS Constitution performance measure.

5. Procurement Process

5.1 The approach that CCG's can use to secure services is clearly defined as:

- through the contracts with existing providers that they have inherited from PCTs and through future variations in those contracts;

- through enabling patients, when they are referred for a particular service, to choose from Any Qualified Provider (AQP) that wishes to provide the service;

- through tendering for a new or replacement service, i.e. identifying the single exclusive provider or group of providers that will be chosen to provide that service

5.2 The CCG is also required to comply with European legislation on procurement and section 75 of the Health and Social Care Act 2012, relating to procurement, patient choice and competition. Therefore as a statutory body, the CCG will need to adhere to legislation that governs the award of contracts by public bodies, including the Public Contracts Regulations 2006, and will need to satisfy the obligations of transparency, equal treatment and non-discrimination set out in the regulations. Section 75 of the Health and Social Care Act 2012 also makes it mandatory for CCG's to:

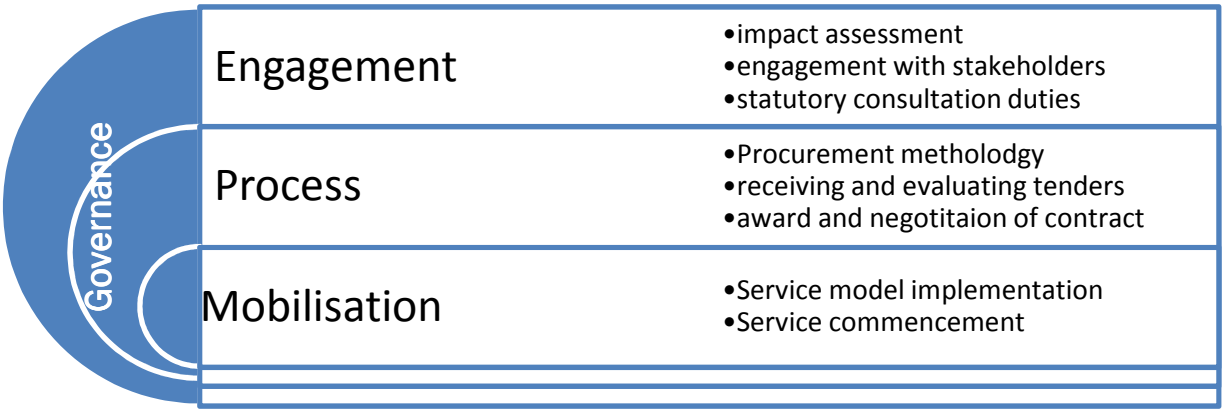
- adhere to good practice in relation to procurement
- do not engage in anti-competitive behaviour
- and protect and promote the right of patients to make choices about their healthcare

5.3 Decommissioning notices which need to be served either 6 or 12 months in advance of any effect or impact, serve as a signal to the provider that commissioners wish to see a change in service. Therefore the serving of a decommissioning notice will not always result in a service being decommissioned. Providers treat decommissioning notices as an indication that a change is required.

5.4 Under the new regulations, NHS money can only be legally spent through one of the two permitted competitive markets, AQP or competitive tendering, and any other way to

arrange services is now illegal (except for the contract renewals permitted for previously tendered contracts).

5.5 The procurement process encompasses a number of key components which are described in the diagram below. The governance function is in place for entire process and is the mechanism by which the Governing Body and/or Executive (depending on contract value) assure and maintain oversight of the procurement process.



6. Next Steps

6.1 Wave 2 procurement is in the commencement phase and is currently in the process of securing a provider to undertake an independent impact assessment and statutory consultation with respect to wave 2 procurement specialities. The specification for this work seeks a provider with expertise to undertake an Integrated Impact Assessment to cover the following areas:

- Health outcomes;
- Statutory and demographic specific equality groups (equality assessment);
- Health inequalities;
- Travel and access; and
- A financial and clinical independency impact assessment to their main providers; North West London Hospitals NHS Trust and Imperial College NHS Healthcare Trust.

6.2 We are seeking a three stage approach to our work; a pre-consultation, mid consultation and a post consultation impact assessment. The impact assessments will be used to inform and provide assurance for the engagement phase of this procurement.

6.3 The specification further sets out that NHS Brent CCG are seeking a provider with ability and proven track record of undertaking the public consultation and stakeholder engagement. This includes engagement with Brent Healthwatch and the general public, voluntary community organisations and specific patient groups in the borough.

6.4 NHS Brent has four desired outcomes from the proposed patient and public consultation:

- That key patients and stakeholder groups are informed about the proposed procurement and the process by which it will take place.

- An understanding of the impact of the procurement on patient and stakeholder groups by NHS Brent in a medium that allows the development of effective management strategies.

- Clear input into the service specification from patients and key stakeholders including desired benefits defined and prioritised.

- Evidence of meeting the statutory duties in respect of patient and public engagement and equality.

6.5 For wave 2, the procurement will be performed through a competitive dialogue process and the scope of service change will be decided through active patient engagement and discussions with prospective providers. Patient engagement supporting the procurement will be a two stage process. Firstly giving patients the chance to input into the service specification and secondly, the chance to comment on the service specification. Following any changes to service models there will be a further piece of engagement from the existing and any new provider to ensure that there is a seamless transition for patients and that any clinical risks are minimised.

6.6 Once we have selected a provider to undertake the impact assessment and consultation the CCG will engage with its EDEN Committee and the Health Partnerships OSC with regard to the plan to confirm that the plan is robust.

6.7 An outline timescales for wave 2 procurement is set out below. These are draft until we have confirmed with the provider undertaking the impact assessment the feasibility of these timescales given the scale of the assessment and formal consultation requirements.

Timescale	Activity
October 2013	• Commission integrated impact assessment and formal consultation and engagement • Agree timescales with providers for each component of the impact assessment
November 2013	• Engage with HOSC and EDEN Committee on the impact assessment and consultation plans agreed with the provider
Dec 13 to Jan 14	• Shortlisted potential providers identified
Jan to Mar 2014	• Integrated impact assessment starts
Jan to May 2014	• Formal consultation and engagement starts with providers, patients, the public and partners
Feb to May 2014	• Procurement process via competitive dialogue starts • Discussing with potential providers services that could be provided in the community that would provide high quality outcomes for patients, enable integrated services and encourages effective partnership with patients and their GPs
April 2014	• Consultation on draft specification with patients, partners and public
May 2014	• Successful bidders selected
June to Sept 2014	• Mobilisation phase which includes: • working with the new provider on establishing the new service • informing patients about the new arrangements • ensuring safe and seamless transfer of care

Brent	**Health Partnerships Overview and Scrutiny Committee 8th October 2013** **Report from Assistant Chief Executive**
For Action	Wards Affected: ALL

Pathology Service Serious Incident: Update Report

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that following a serious incident involving the pathology service, and a subsequent Root Cause Analysis, an Action Plan has been put in place to address the key issues identified.

1.2 This report provided by Brent CCG gives a short update on plans for improving the courier service used for the pathology samples, which it says is now the only outstanding item from the Root Cause Analysis.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to question officers on the status of other actions in the action plan that resulted from the RCA, which are not covered in the report.

Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

Cathy Tyson
Assistant Director of Policy
Tel – 020 8937 1045
Email – cathy.tyson@brent.gov.uk

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Brent
Clinical Commissioning Group

Update report to the Brent Health Overview and Scrutiny Committee on Pathology transport

Pathology Courier Service

Background

The courier service was not part of the pathology service and was procured through a separate tendering process. The existing service provider was the successful bidder and the service continues to be provided by Revisecatch Limited (Courier Systems) who were appointed in October 2012 for a period of four years and seven months to tie in with the Pathology service.

Issue

Although not directly associated with the problems described in the RCA, transportation and delivery times appear to play a (seasonal) role in the variation of potassium levels; in that they add to the instability of the samples due to fluctuation in temperature during storage at the GP practice and or during transportation to the laboratory in both summer and winter.

In the only outstanding item from the RCA, Dr Patel co-author of the RCA and Clinical Responsible Officer (CRO) for pathology is leading a task and finish group which includes Courier Systems to;

- Create best practice for storage of samples guidelines for GP practices

- Pilot a hub and spoke process whereby bikes pick up from the practices and travel a far shorter distance to a hub where samples are transferred to a temperature controlled van for transportation to the laboratory.

The task and finish group intends to have the pilots working by the third week in October to ensure this covers the period of the winter months. The pilot will report its initial findings in February to the CCG Executive and then to the HOSC.

Sept 2013

Brent	**Health Partnerships Overview and Scrutiny Committee 8th October 2013** **Report from Assistant Chief Executive**
For Action	Wards Affected: ALL

Central Middlesex Hospital UCC Serious Incident: Update Report

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that there was a serious incident at Central Middlesex Hospital UCC in 2012 which involved X-rays not being properly reviewed or acted upon. At the last meeting in July the committee requested a short report providing information on whether further treatment had been required by any of the affected patients and what improvements had been made to the monitoring of the contract.

1.2 The attached report provides an update on how the affected patients were categorised and contacted (if deemed necessary).

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to ask officers for the information it actually requested, namely:

- what treatment had been required for patients affected;
- improvements made to the monitoring of the contract;

and to question them further on these if necessary.

Contact Officers

Mark Burgin
Policy and Performance Officer
Tel – 020 8937 5029
Email – mark.burgin@brent.gov.uk

Cathy Tyson
Assistant Director of Policy
Tel – 020 8937 1045
Email – cathy.tyson@brent.gov.uk

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Brent
Clinical Commissioning Group

Update report to the Brent Health Overview and Scrutiny Committee on the Urgent Care Centre X-ray incident

Incident in Brief:

There was a discovery of a substantial number of x-rays (some un-reviewed) that were not automatically sent to the patient's GP surgery. - The Governance team undertook a full Root Cause Analysis Investigation (RCA) and submitted to NHS London at the beginning of June 2012. Throughout the investigation a Clinical Governance Manager from the Governance team worked closely with NHS Brent.

The UCC undertook a comprehensive programme of tracing those patients that required follow up appointments following the discovery.

The majority of patients were contacted in the following weeks and offered follow up appointments. This process involved contacting the patients by letter which was then followed up with a telephone call to ensure they had received and understood this information. It was clearly explained to each patient what had happened and the process agreed for following up their individual conditions.
The GP surgery was also informed and given the appropriate briefing about the condition, x-ray result and to expect the patient to attend a follow up appointment.

In cases where the patient had moved GP surgeries the patients were traced and the same process followed.

There were a number of "cold cases" (those who could not be initially traced), 11 in total, which took considerably longer to trace. It is not unusual for a number of these to remain outstanding when a Serious Untoward Incident is closed but by December 2012 all patients had been traced and contacted and had completed their follow up.

Patient Impact

A process was put in place for these x-ray reports to be clinically reviewed by a competent team of radiographers and doctors. The cases were then categorised using the following traffic light system.

Category	Number	Description
Red	• 97	• Confirmed fracture/ other pathology which may have altered the course of treatment given.
Amber	• 153	• An abnormality identified but on review of patient consultation notes, appropriate care was provided.
Green	• 5728	• No fracture or abnormality identified and treated appropriately at time of consultation.

The 97 patients were contacted in a two stage process

Tele Consultations	Brent
Closed - no further action Including patients treated appropriately at the time of presentation.	66
Face to Face Consultation required Patients who require a face to face follow up consultation who we are attempting to contact to book an appointment.	6
Managed by Alternative Provider Patients who are undertaking treatment with an external provider.	1
GP Referral required Referral required to be actioned by GP	2
Advised to see GP, if required	3
Sub Total	**78**
Patients moved to Stage 2 Patients who have been contacted and were booked a Face to Face Follow Up appointment	19
Total	**97**

Face to Face Consultations

Stage 2 – Face to Face Consultations	Brent
Closed - no further action	8
To go back to GP, if required	0
Referral required – non fracture clinic	2
Referred to Fracture Clinic	9
Total	**19**

All patients have now been successfully treated and discharged.

Sept 2013

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Health Partnerships OSC

Work Programme 2013-14

Meeting Date	Item	Issue
Recurring	Emergency Services	Current issues around emergency services/A&E at North West London Hospitals and immediate, mid and long term plans to address current problems and improve services.
Recurring	NWLHT and EHT Merger	Update on the merger between North West London Hospitals Trust and Ealing Hospitals Trust and on current progress against financial targets.
Dec/Jan	Current diabetes services and future commissioning	To establish what services are currently provided and what the future commissioning plans are by the organisations now charged with providing them.
TBC	Public Health	At the June 2013 HOSC members commented of the need to receive regular reports on how public health services were working.
TBC	Health Visitors	Following previous concerns about the recruitment and retention of Health Visitors, the committee
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will consider the strategy and respond to the consultation.
TBC	Palliative care	Following a presentation from the CCG followed by St Luke's Hospice in March 2013, the committed requested that the CCG return with a more detailed report on Palliative Care in Brent and that included the Brent End of Life Strategy which was not available to members at the time of the meeting.
TBC	Diabetes and physiotherapy services – plans to re-commission services in Brent	NHS Brent plans to re-commission diabetes and physiotherapy services in the borough. The committee should consider the plans for the new services, as well as the consultation plan.
TBC	Housing Advice in a Hospital Setting	Care and Repair England has produced a report on integrating housing advice into hospital services. Brent Private Tenants Rights Group would like to bring this report to the committee to begin a conversation on the best way to take this forward in Brent.
TBC	Health Inequalities Performance	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This

	Monitoring	framework will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.
TBC	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.
TBC	Fuel Poverty Task Group	Recommendation follow up on the task group's review.
TBC	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.
TBC	TB in Brent	Added at the request of the committee (meeting on 20th Sept 2011).
TBC	GP access patient satisfaction survey results	In December 2011 the results of the six monthly patient survey will be published. Members should scrutinise the results with Brent GPs to see how their initiatives to improve access are reflected in patient satisfaction.
	Teenage Pregnancy	Members have asked for a report on teenage pregnancy in Brent, the services available and conception rates amongst teenagers.
	Abortion services in Brent	Councillors have asked for a report on abortion services in Brent, and the abortion rates in the borough, including repeat abortions. This could include a more general update on sexual health provision in Brent.
TBC	Brent MENCAP Update on work	At the November 2012 HOSC members heard from MENCAP on their work around Health Services for People with Learning Disabilities. Members requested an update on MENCAPs work at a future meeting.
TBC	Diabetes Task Group	Update on progress of the Diabetes Task Group recommendations.